# MONTANA LEGISLATIVE BRANCH

## Legislative Fiscal Division

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**Legislative Fiscal Analyst**
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# Minutes
# HJR 1 Subcommittee

February 7 & 8, 2002
Helena, Montana

The third meeting of the House Joint Resolution (HJR 1) Subcommittee was called to order by **Senator Bob Keenan**, Chairman, on February 7, 2002 at 8:30 a.m., in Room 172 of the Capitol Building. The following members were present:

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| Senator Keenan, Chairman | Representative Price |
| Senator Pease | Representative Jayne |
| Senator Stonington | Representative E. Clark |
| Senator Franklin | |

Senator Cobb was excused.

## Approval of Minutes

**Representative Clark** moved that the minutes of the November 28, 2001, meeting be approved as presented. The motion carried unanimously.

Information/materials requested from the subcommittee at the November 28 meeting are:

- Budget status report update from DPHHS and AMDD
- List of budget reductions under consideration
- Expenditures on the list of high-cost children
- Update on the regional service area planning
- MDBOV role and site review report
- Detailed explanation of MDBOV budget
- Amount of money being spent for veterans at the MSH and the MHSP
- Mental Health Advocacy Program (MAP) budget

Lois Steinbeck, Senior Fiscal Analyst, Legislative Fiscal Division (LFD), reviewed the two primary policy questions to be addressed throughout the meeting.

- What is the legislative policy regarding treatment or incarceration of persons with a mental disease or defect who come into contact with the criminal justice system?
- What is the legislative policy regarding the role of the Montana State Hospital (MSH)?

**Statutes and Court Cases Governing Civil and Forensic Commitments to MSH**

Susan Byorth Fox, Research Analyst, Legislative Services Division (LSD), presented the report Mental Competency of the Accused (Exhibit 1). The report is an analysis of statutes relating to mental disease or defect and criminal procedure of "forensic" patients found at Title 46, chapter 14, MCA. These statutes are applicable when a person is alleged to have committed a crime and comes to the attention of the criminal justice system and the person's mental state is recognized as an issue. The four categories discussed as part of the "forensic" population at the MSH are: 1) Court-ordered evaluation; 2) Unfit to proceed or incompetent to stand trial; 3) Not guilty because of mental disease or defect; and 4) Guilty and suffering from mental disease or defect.

Other issues raised:

**Inter-institutional transfers**. Alternative placement of the various categories of forensic patients could be explored with the caveat that only persons found guilty of a crime could be held in a correctional facility (53-1-209, MCA).

**Appeals**. Persons sentenced under 46-14-312, MCA, do not have the same right to appeal as others who are convicted of a criminal offense. There appear to be two areas for which clarification or statutory change may be appropriate.

**Inappropriate admissions to MSH**. Clarification should be sought as to why an admission is considered inappropriate. There are differing legal and medical standards that involve state policy and fiscal restraints.

**Parole**. A mental health parole has been raised as a possibility. This alternative could be available only to those persons who have been convicted of a crime, individuals who are guilty but mentally ill.

**Forensic patients being billed and paying for their own care**. It has been suggested that forensic patients should be required to pay for their care on the same basis as those in on a civil commitment.

Greg Petesch, Director/Code Commissioner, Legal Services Office, LSD, discussed the distinctions between civil commitment process and the process by which people come into the mental health system in what is called the "forensic" category. The distinction in a civil commitment is the recognition that the person has a mental illness and he/she may be a danger to self or others with the focus on securing treatment. On the forensic side, the requirement is that the person have a mental disease or defect and is a threat to others or property. The focus on forensic patients is on protecting society from them, not getting treatment for them from a medical standpoint. Mr. Petesch also discussed several state and federal court cases governing civil and forensic commitments to MSH.

Olmstead 1999

States are required to provide community based treatment for persons with mental disabilities when treatment professionals determine that community placement is appropriate, the affected person does not oppose community treatment and the community treatment can be reasonably accommodated. Unjustified isolation of a mental patient is a form of discrimination based upon a disability.

K.G. F.

In K. G. F. the court recognized a very specific lack of due process protection for individuals who are going to be deprived of a liberty interest.

Houghton v. South

There is no equal protection or due process violation where the category of forensic patients has a means available to them for their release.

Zion v. Xanthopoulos

Conditions for punishment or retribution in a parole and probation type setting are inappropriate in dealing with acquittal because of mental disease.

State v. Wood 1997

Continued confinement under the not guilty but mentally ill category does not require a showing of serious mental illness. Continuing confinement only shows that a person has a mental disease or defect and a finding from the court that he/she is a threat to persons or property.

State v. Wooster 1999

The court noted there is no definition of mental disease or defect in Title 46, chapter 14, MCA. The Montana Supreme Court adopted a definition from New York Criminal Procedure.

**Senator Stonington** asked if the current definition of a mental illness is adequate and what would be the advantages or disadvantages of putting a definition of mental illness in the criminal procedure statutes. Mr. Petesch stated the definition is adequate for the purpose of the court. The legislature should review the definition in terms of the policy it wants to pursue and obtain input from practitioners as to what the terminology means.

## Panel Discussion on the Corrections System and the Mentally Ill

Participants of the panel were: **Lorene Thorson**, Senior Fiscal Analyst, LFD; **Sally Johnson**, Administrator, Professional Services Division, Department of Corrections (DOC); **Ed Foley**, Institutional Probation and Parole Officer; **Louise Goss**, Mental Health Community Liaison; and **Bonnie Adee**, Mental Health Ombudsman.

Ms. Thorson discussed the report on Mentally Ill Offenders in the Corrections System (Exhibit 2). The report provides information on who the mentally ill are in the correction system and how they compare to the general prison population. In 1998, the number of incarcerated with a mental illness was four times higher than the number of people in state mental hospitals. Approximately 16 percent of the prisoners in the correction system are mentally ill. Statistics reveal that the mentally ill are more likely than other offenders to have committed a violent offense, have a longer criminal history, and are incarcerated for longer time periods than an inmate committing a similar offense.

Ms. Johnson distributed a handout on Key Information About Inmates with Mental Illness (Exhibit 3). The report provides data for the Montana State Prison (MSP), Montana Women's' Prison (MWP), Crossroads Correctional Center (CCC), and Missoula, Cascade and Dawson County regional jails.

The current data does not provide an "apples to apples" comparison. The DOC is working on a major medical/mental health data project to improve consistency of terms and quality of data. However, the patterns are fairly consistent within the state and nationally.

Mr. Foley explained the role of an institutional parole officer. Mr. Foley is 1 of 4 institutional parole officers at the MSP. Each of the regional prisons also has a parole officer. The position of institutional parole officer was designed as the bridge between the prison and Board of Pardons, and between the prison and the field officers. Any release from MSP goes through the office. Through a combined effort with DOC and Western Community Mental Health Center, a mental health liaison position was created for both the women and men's prisons. This position helps with community placements.

Ms. Goss explained her position as the Mental Health Community Liaison. Ms. Goss assists individuals being released from the MWP, Alternatives Incorporated (pre-release program), offenders required to work with adult probation and parole, and individuals released from MSP residing in the Billings area. Ms. Goss distributed a packet from the Montana Women's Prison Mental Health Services (Exhibit 4), which is a compilation of all the paperwork from the initial intake through the time of discharge. Ms. Goss has a caseload between 43 and 48 people. To be eligible for the Mental Health Community Liaison program, the individual must be currently in the custody of the following: DOC, MWP, MSP, or be assigned to the DOC through probation and parole. The client must have a diagnosed mental illness as per the standard for the Montana Health Service Plan (MHSP). A doctor or a licensed clinician must make the diagnosis. Upon discharge the client must qualify for either MHSP, Medicaid, or have private insurance to receive mental health services in the community.

Ms. Adee briefly discussed the Ombudsman Report for July 1, 2001 through February 1, 2002 (Exhibit 5). During that time contacts to the Ombudsman's office having to do with the criminal justice system was about nine percent. In the first 6 months of this year contacts about the criminal justice system was up to 13 percent. The percentage of calls about Child and Family Services also increased from last year (4 percent vs. 6 percent). Based on the data received during the past fiscal year, the Ombudsman made the following recommendations to the legislature and the Governor's Office:

Recommendations

? ? Determine the desired outcome for changes.

? ? Appropriately fund the changes.

? ? Provide alternatives for mentally ill offenders before they go into the criminal justice system and at the exit in terms of a place that better addresses treatment needs while also addressing the need for supervision and correctional placement.

**Oversight issues**

SFY 2002 Budget Projections – November 2001 Status Report (Exhibit 6) – Ms. Steinbeck reviewed the budget status report for the Mental Health Program. The projected deficit for the Addictive and Mental Disorders Division (AMDD) is about $100,000 general fund after all the mental health reductions have been implemented.

November FY 2002 Budget Status Report Summary (Exhibit 7). This report shows a projected general fund deficit of $73,005. The primary change from the October report is that the cost mitigation plan reducing the Medicaid cost over runs has been included in the expenditure projections.

Pat Gervais, Senior Fiscal Analyst, LFD, explained that at the last SB 454 meeting representatives from the Child and Family Services Division (CFSD) indicated that they had received 3 or 4 referrals regarding children who were or would be discharged from placement because there was not a payer for room and board. Indications were that one of the referrals was from a parent who was seeking to relinquish custody in order to access services. Other cases were providers who were concerned that the children would not be able to be served in their home at discharge.

Dan Anderson, Administrator, AMDD, DPHHS, explained that there are three levels of services. Residential treatment is not affected by the reduction because Medicaid rules allow DPHHS to include room and board as part of the overall Medicaid rate paid. The levels of care that are affected by discontinuation of payment for room and board are therapeutic group home care and therapeutic foster care. Treatment is an allowable Medicaid cost, but room and board is not. There are about 600 children in therapeutic group home and foster care at any given time. DPHHS was paying room and board for about 100 children per month at $28.00 per day with 100 percent general fund. Mr. Anderson stated that AMDD is continuing to fund 31 slots by providing block grants that providers can use to pay room and board.

Chuck Hunter, Administrator, CFSD, stated that there are about 125 children in placements where room and board payments were discontinued. CFSD is receiving calls and referrals and there is some debate on how to handle the situation. The department is telling staff they will not take the referrals and they will not consider the children abused and neglected merely to access mental health services. If the department takes some of those children the costs will be moved to CFSD budget, which is at a higher general fund cost.

CSED Budget – Ms. Gervais reported that CSED received notification in October on the amount of federal incentive fund award for federal fiscal year 2000. The notification indicated that the division had over drawn about $1.0 million of incentive funds. Based on that information and the final regulations regarding the calculation of incentive funds published in January 2001, the department revised its estimate of the federal incentive funds that it would receive. It appears that the federal incentive funds will be about $2.0 million less each year of the 2003 biennium than what was estimated during session. (Federal incentive payments are deposited to state special revenue. Each dollar of the state special revenue is matched with $2.00 of federal money.) In addition, the department has a repayment due for fiscal 2000 and is estimating it will have to repay funds for federal fiscal 2001. Information received from the department indicates that general fund from reverted appropriations will be used to repay federal fiscal year 2000 and 2001 overpayments.

Reductions include elimination of the customer service center (in fiscal 2000 the call center received 177,000 calls) and reducing staff in the division by 9 positions. With those reductions the department estimates that at the end of the biennium it may be short about $800,000 in state special revenue which would result in a shortage of $1.6 million in federal funds for a total shortage of $2.4 million.

**Panel on Commitments, Community Treatment, Criminal Sentence or Release of Mentally Ill Persons Who Come in Contact with the Criminal System**

Participants of the panel were: **Leo Dutton**, Deputy Sheriff, Lewis and Clark County; **Mark Lerum**, Assistant Chief of Police, Helena Police Department; **Sharon Howard,** Chief Medical Officer, Cascade County Adult Detention Center; **Gene Durand**, Director of Missoula County Adult Mental Health Services; **Leslie Garvin**, Chief Legal Counsel, Mental Disabilities Board of Visitors; and a **Family Member**.

Officer Dutton explained his role on the street in dealing with the mentally ill. His training at the Montana Law Enforcement Academy in dealing with the mentally ill was about three hours of crisis intervention, which basically was how to handle someone who is out of control and to bring the situation into control. Officer Dutton also received additional training as a paramedic. The officers rely heavily on people who are trained in mental health and Helena has a crisis line that is utilized. If an individual makes a threat directly or indirectly he/she is taken to the emergency room for an evaluation. Officers are often tied up transporting mentally ill persons to MSH and back for hearings. Officers need more training and a mental health professional to evaluate the person at the scene, which might prevent the person from being handcuffed and taken to the hospital.

**Senator Stonington** asked what the amount time the department spends transporting mentally ill people to MSH and back for hearings. Officer Dutton responded about 4 hours per day and sometimes 2 or 3 days a week.

Officer Lerum, Assistant Chief, discussed the department's policy regarding the mentally ill. Basically, if the person makes any threats he/she is taken to be evaluated by a professional.

Since January 2001, the Helena Police Department has taken into protective custody 115 individuals and the Lewis & Clark County Sheriff's Office has taken in 25. The K. G. F. decision has increased the amount of time it takes to process a protective custody case and it also involves more transports for the Sheriff's Office. Helena used to have a crisis response team that would respond to the location where the officer was and they would make the determination if the person needed further evaluation. This action would help prevent the individual from having to be transported in handcuffs to the hospital.

Ms. Howard described the function of the Cascade County Adult Detention Center. The facility has beds for 365 inmates. About 135 beds are dedicated to DOC inmates. Determining what the inmate/patient problems are is complicated by the use of drugs and alcohol and it is not clear if someone is mentally ill. Also, confidentiality laws make gathering a person's history a difficult process especially if that person is inebriated or under the influence of other drugs. About half of the costs spent on medication is for psychotropic medications, which is well over half of what would be spent to take care of all of the physical illnesses of the people in the facility.

Ms. Garvin explained as chief legal counsel, part of her job is to look at every commitment order for the MSH. The not guilty but mentally ill commitments can turn in to a life sentence. Statute requires that the not guilty but mentally ill and the guilty but mentally ill receive custody, care and treatment. What happens when those patients reach maximum benefit of hospitalization or are no longer a danger to society? Guilty but mentally ill plea bargains are a legitimate tool in a criminal case but should not be used to keep someone out of prison. There are patients who come to the MSH on a plea bargain who do not belong there. It affects the people at the hospital that want and need the treatment. In the criminal system a person always has the right to remain silent. K. G. F. will not affect the criminal justice system in having more people found not guilty because they exercise their right to remain silent. It will however; affect the court ordered detentions. More patients come to the hospital on court ordered detentions because their court cases are taking longer to develop before they are heard, they stay anywhere from 10 to 20 days before they go to court, during that period of time they receive no treatment because no treatment is ordered and they usually decompensate. Ms. Garvin stated she would be willing to work on the definition of mental illness.

**Senator Stonington** asked if teleconferencing is being used. Ms. Garvin responded it is not being used at the MSH and she does not know if it is used in the communities.

Mr. Durand is the Director of Missoula County Adult Mental Health Services. The facility provides services to about 1,300 unduplicated clients a year. In Missoula, three types of involuntary commitments for community-based treatment are used: civil community commitments, civil conditional releases, and criminal conditional releases. The most effective and least restrictive means to provide community based treatment is through an assertive outreach program. One thing that can cut down on the number of involuntary commitments is an improvement in front door access to treatment. All civil and voluntary commitments in Missoula have to be initiated through the Missoula County Adult Mental Health Services. The Crisis Response Team (CRT) provides a gate keeping function in Missoula. An individual can be committed on an involuntary basis to receive treatment without being forced to go to MSH. Missoula has a medication administration program, acute community hospital, hospital alternative program, adult case management program, day treatment, and a grant to establish a team that is similar to a PACT team that specifically targets people with co-occurring disorders. PATH is a program designed to outreach people in transition and from homelessness.

Family Member – The mother of three children, one son who has been diagnosed as having bi-polar. Her son doesn't look sick so people expect him to be normal. She spends 80 percent of her day trying to understand his illness. She explained how difficult it is to find the services and get them coordinated. When applying for services she was judged and the process was very dehumanizing. It is often implied that the parents caused the disease. Mentally ill people need advocates to help them find and access services.

**Senator Keenan** asked Officer Lerum how many of the total protective custody cases are duplicative. Officer Lerum stated about 20 percent are repeats. Helena has a lot of transients passing through that are mentally ill.

**Senator Stonington** asked Mr. Durand to explain single portal authority. Mr. Durand stated that single portal authority is similar to what occurs in Missoula County at the mental health system. The system responsible for the care and treatment of individuals would be the only mechanism for a person to be committed. **Senator Franklin** described it as a single entry point to a continuum of care.

**Senator Stonington** stated she would like to work on the definition of mental illness with Ms. Garvin.

**Public Comment**

Anita Roseman, Montana Advocacy Program, stated that it might not be legal for the DPHHS in conjunction with providers to determine where a person should be at any one time during the commitment period. If the proposal is that commitments would be to either the DPHHS or to regional SAA's rather than MSH or community commitments, there would be one kind of commitment and the providers in conjunction with the department would somehow decide whether the person is more appropriately placed in the MSH or in the community and that would be done without court process beyond the initial commitment order.

**Issues Identified By Staff**

- Definition of fitness to proceed and mental disease in statute
- Potential for a life sentence if committed to MSH on a finding of not guilty due to a mental disease or defect
- Potential for sentence review process for forensic commitments to MSH
- Mental health judge designated to hear all mental health cases
- Communicate with Supreme Court regarding K.G. F.decision
- Focus on diversion and re-entry from the criminal justice system
- Provide training to law enforcement and other first responders
- Modify statutes to allow courts an avenue to allow for early release of inmates with a mental illness with intense supervision
- Train probation and parole officers to be better equipped to deal with persons with a mental illness
- Continue funding for programs designed to treat persons with a mental illness who are also chemically dependent

- Continuum of care between the MSH and the community centers
- Give consideration to the concept of single portal authority/ single entry point to a continuum of care
- Look at involuntary commitments to the SAA to include MSH that would allow free movement for the client throughout the service system without continuous court hearings
- Consider MHSP covering acute hospitalization
- Review process to allow local providers to determine financial eligibility for MHSP

**Senator Keenan** distributed copies of the Meeting Summary: Forum on Mental Health Commitment Law Issues (Exhibit 8). AKA: Mental Health-Law Enforcement Rendezvous. The purpose of the forum was to exchange ideas and discuss potential for legislative and/or other solutions to issues related to MSH commitments. Included in the summary is a list of statutory changes to be considered by this committee.

Veterans' Issues Update (Exhibit 9) – Sheri Heffelfinger, Research Analyst, LSD, distributed an update on the Recent Actions of SJR 5 Subcommittee On Veterans' Affairs (Exhibit 9). The issues raised are:

**Accessibility to VA services for Montana's veterans with mental illnesses.**

? ? Lack of VA mental health services shifts costs

? ? The VA is not acting as a partner with other mental health providers

The VA's Office of Medical Investigations conducted a site visit to Fort Harrison for three days. During the visit, the team heard from veterans, service providers, and employees on a variety of issues. The team determined that a second site visit was needed. A report will be published in 45 to 90 days and a redacted version of the report will be made public. The preliminary recommendations do not address special needs of mentally ill veterans. The SJR 5 subcommittee instructed staff to develop a bill draft for further consideration.

**Friday February 8, 2002**

The third meeting of the HJR 1 subcommittee reconvened on Friday, February 8, 2002, and was called to order at 9:15 a.m. by **Senator Eve Franklin** at the Montana State Hospital. The following members were present:

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| Senator Keenan | Representative Jayne |
| Senator Stonington | Representative E. Clark |
| Senator Pease | |

Senator Keenan arrived shortly and assumed the chair. Senator Cobb and Representative Price were excused.

Judge Mizner, is the District Court Judge for Powell County (MSP), Anaconda-Deer Lodge County (MSH, DUI Treatment Unit), Phillipsburg and Granite County. Judge Mizner handles all involuntary commitments for the three counties, involuntary commitments to MSH, and all recommitment hearings for the state. Forensic review of criminal cases has to be undertaken once a year. The patient can petition for review by the court or the hospital and in some cases he or she is determined not to be dangerous and can be released to the community. A follow-up system is needed for patients with a mental illness once they are released from MSH and a secure detention facility is needed for dangerous offenders with a mental illness to obtain an evaluation. Detention costs for Anaconda-Deer Lodge County this year are estimated at $38,000. Some of the costs will be shifted to the state to the extent that funds are available.

Mike Grayson, County Attorney, Anaconda-Deer Lodge, explained that the majority of criminal cases that have resulted in guilty but mentally ill placement at MSH are people that placement anywhere else would be inappropriate. The people have been evaluated, they are competent and understand what they did was wrong but they have significant mental health issues. Mr. Grayson distributed a handout on 2001-02 Anaconda-Deer Lodge County Emergency Mental Health Detentions, Duration and Result (Exhibit 10). The average number of days of pre-commitment detentions prior to K.G. F decision was 2.89. Since K.G. F. the length of detention has almost doubled. The percentage of people being committed to the state hospital has not changed pre or

post K.G. F. Mr. Grayson agreed with Judge Mizner that there is no follow-up system once a person is released from MSH.

**Senator Keenan** stated that a letter from the committee would be drafted to the Supreme Court outlining concerns regarding unintended consequences of K.G. F.

## Montana State Hospital Discharge Process and PACT

Participants of the panel were: **Dr. Thomas Gray, Psychiatrist,** MSH; **Randy Vetter**, Admissions Coordinator, MSH; **Janet Schroeder**, PACT Team Leader – Billings; **Jenny Kelly**, PACT Team Leader – Helena.

Dr. Gray explained the diagnosis used for the patients at MSH is a five-axis system. The majority of the patients at MSH are in persistent danger of severely hurting self or others, persistent inability to maintain minimal personal hygiene or serious suicidal acts. Preparation for discharge depends on an interdisciplinary evaluation in terms of treatment, stabilization of symptoms and what is needed in an outpatient setting.

Mr. Vetter gave an overview of the discharge planning process. The process begins shortly after a person is admitted and is part of the social assessment process that is completed on each patient admitted to the hospital regarding involuntary commitments, voluntary admissions, or criminal court orders. An initial discharge plan that is more detailed is completed by the social worker assigned to the patient. The discharge plan is completed when all the services necessary to help the person maintain in a less restrictive setting are in place and the person's symptoms are such that the person can be safely released back into the community.

Ms. Schroeder discussed appropriate and inappropriate diagnoses for PACT. PACT services are intended primarily for individuals with psychiatric illnesses that are severe and persistent such as schizophrenia and other psychotic disorders. PACT services are also appropriate for some people who experience significant disability from other disorders such as obsessive compulsive disorder, post traumatic stress disorder, anorexia nervosa, and disassociate identity disorder. The most difficult clients are those with borderline personality disorder and those with a substance abuse or chemical dependency problem that is primary. The easiest are the Axis I diagnoses

mainly because with medication their symptoms will decrease and stabilize. The monthly PACT rate is about $800 a month per client and out of that PACT provides psychiatric care, therapy and case management. Inpatient at the hospital, group home, day treatment, and chemical dependency treatment are not provided. PACT does not get paid for services while the client is in a group home. Referrals come from MSH, from the mental health centers, and from community hospitals. Finding affordable housing, keeping apartments clean and motivating clients to go to group therapy are some of the challenges.

Ms. Kelly discussed the Helena PACT team. The start-up process involved NAMI, mental health administrators and DPHHS. The start-up had some rough beginnings with social workers and the team not being sure what kind of clients to take and who could be helped. The team needs to be well trained and carefully selected. The Helena PACT team had a turnover of 9 people in 2 years. It was difficult for the community to absorb 24 mentally ill people in a short period of time. Finding affordable housing and employment were also very difficult. Referrals come from MSH, community hospitals, community case managers, crisis house staff, PACT staff, from out of state, and families.

## Services for Persons with Both a Chemical Dependency and Mental Illness

Participants of the panel were: **Roland Mena**, Chief, Chemical Dependency Bureau, AMDD; **Judy McGovern**, Director of the Gateway Program and Coordinator for Co-Occurring Project in Great Falls; **Peg Shea**, Program Director, Turning Point, Western Montana Regional Community Mental Health Center; **Emory Jones**, Member, Co-Occurring Task Force; and Michelle McKinny, Psychologist, MSH.

Mr. Mena discussed co-occurring initiatives in AMDD. In February 2000, the division conducted three public forums to gather information on issues related to access, integration of services and other problems regarding treating people with co-occurring disorders. As a result, a task force of 15 persons was convened. Initiatives from the committee were: bring key leaders from communities together to educate and bring attention to the issue; identify unique issues in addressing the needs of people with co-occurring disorders; and develop a plan of action for members going back to the community. The second task was to assist the department with

developing a draft RFP. The RFP was released mid summer and two programs were funded from that effort. The goal is to have all programs capable of dealing with co-occurring disorders.

Ms. McGovern discussed the function of the Gateway Recovery Center. The center provides outpatient services and has worked with people who have a dual diagnosis. Historically, the people that come to the center are not severely mentally ill. The co-occurring task force has been a valuable tool in working out some of the problems that come up. Benefis Behavior Health Care joined as a partner in the pilot project to co-facilitate groups and provide a local facility for people who need more intensive services. The project has money to cross train staff. The biggest challenge will be funding in the future.

Ms. Shea explained one incentive to treat co-occurring disorders is being able to bill Medicaid for chemical dependency services for adults. Another incentive is the RFP. Instead of putting all of the money into one community they decided to enhance existing Medicaid MHSP services and create new services. Kalispell needed an enhanced group home that could manage substance abuse and mental illness. Butte needed a detoxification center, so an integrated crisis center that can both detoxify and stabilize psychiatric disturbance was developed. In Missoula both the substance abuse and adult mental health have waiting lists and about 60 percent of the individuals that come through both detoxification and supported housing have a co-occurring illness. Missoula now offers detoxification to dual disorder individuals who aren't necessarily homeless and changed the model so it can accommodate suicidal patients.

Mr. Jones discussed the shift in treatment with co-occurring disorders and what occurs more specifically clinically. The co-occurring task force is developing resources and training, coordinating and integrating the available resources in the community. An eight-week training program has been implemented in Missoula that is co-sponsored by both the mental health system and the CD system.

Dr. McKinney works as a staff psychologist in the acute psychiatric program at MSH. She discussed what the hospital is doing in terms of co-occurring disorders. Since July 2001, out of 282 admissions 147 (52 percent) were diagnosed with some type of chemical dependency or

substance abuse issue. The hospital currently has one chemical dependency counselor to do chemical dependency evaluations. The hospital provides AA meetings, chemical dependency groups, step groups and a dual diagnosis group. A dual recovery pathway has been developed to guide patients' treatment more efficiently and effectively; how patients are assessed when they come into the hospital; and outcome measurement.

Ed Amberg, Administrator, MSH, briefly discussed the Montana State Hospital (Exhibit 11). The report includes information on the six programs at the hospital, hospital census, admission types, discharges, annual expenditures, operation budget projection for fiscal 2002, and MSH accomplishments for fiscal year 2000-2001. There is also a list of groups and treatment programs offered by the hospital

Dr. Thomas Gray talked about the needs of the patients regarding medical care, medications, setting, aftercare, legal issues and regulatory issues. In addition to the patients mental illness a lot of them have medical illnesses. The cost to care for the medical illnesses comes out of the hospital budget. The hospital admitted a woman who was paranoid, confused, combative and pregnant with twins. All of her medical care costs will come out of the hospital budget. Medicaid will only pay for persons 21 and under or 65 and older. Medication costs are expected to increase every year.

Dr. Virginia Hill distributed a handout Montana State Hospital Forensic Legislative Issues (Exhibit 12). Dr. Hill talked out about the forensic unit at the hospital. She discussed the kinds of commitments, how many patients are in the forensic unit, what kind of diagnoses they have, what types of crimes they have committed, the treatment opportunities, community placements and what type of services are needed for community placements.

Dr. Polly Peterson, Chief, Department of Psychology, MSH, gave an overview of the clinical programming at the hospital and the residence council. The residence council is a group of residents at the hospital that meet on a regular basis to look at ways they can participate in clinical programming and improving the service and environment at the hospital. The clinical pathway is designed to integrate programs and help identify who should get what programs.

Mr. Amberg reiterated issues raised:

A. What should the average daily population of MSH be?

B. How can that population be achieved?

   a) Cap the census.

   b) Give the hospital a bigger role in managing the population.

C. How should transition between the hospital and the community work?

   a) Support the Pathways program between the hospital and the community.

   b) Provide more transitional care by MSH.

   c) Overlap of services.

**Direction to Staff**

Staff will put together a list of issues and options and will contact committee members to determine if there is a time that members could meet to discuss the issues prior to the May meeting

**Next HJR 1 Subcommittee Meeting**

The next committee meeting is May 14th.

**Adjournment**

Meeting adjourned at 3:50 p.m.

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Sen. Bob Keenan, Chairman

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Diane McDuffie, Committee Secretary